NOAA Health Services Questionnaire

Name _____ E Mail: _____
Last First MI Program _____
Position _____
Birth Date: _____ Sex: ○M ○F Scientist Teacher-at-Sea Other
mm/dd/yy
Work Address _____ Phone _____ (W)
_____ _____ (H)
Cruise dates: _____ SSN: _____
Citizenship: _____ Passport No. _____
Next of kin: _____ Next of kin relationship: _____
Address of next of kin: _____
Emergency Contacts (name and phone no.):
#1 _____ #2 _____
Medical Insurance Company: _____ Policy No. _____

HEALTH INFORMATION

General State of Health: ○Excellent ○Good ○Fair ○Poor
Presently under the care of a physician? ○No ○Yes
Month/Year of most recent Physical Exam? _____ (mm/yy)
Month/Year of most recent Chest X-Ray: _____ (mm/yy) Result_____
List current medications (prescription and non-prescription):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List Allergies: Allergy Reaction

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

List ALL active health problems:

1. _____
2. _____
3. _____
4. _____

Major Surgeries / Hospitalizations / Emergency Room visits

Year Reason

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

List Any Dietary Restrictions:

Restriction Reason

1. _____ _____
2. _____ _____

Name: _____

GENERAL SCREENING

As an adult, have you had or experienced?

Cancer	○N	○Y	Severe Depression	○N	○Y
Tuberculosis	○N	○Y	Paralysis	○N	○Y
Asthma	○N	○Y	Epilepsy	○N	○Y
Hepatitis	○N	○Y	Impaired Mobility	○N	○Y
Chronic Cough	○N	○Y	Severe Hearing Loss	○N	○Y
Coughed up Blood	○N	○Y	Severe Visual Impairment	○N	○Y
Recent unexplained weight gain or loss of 20 or more lbs.	○N	○Y	Periods of Unconsciousness	○N	○Y
			Severe Motion Sickness	○N	○Y
Female only: Are you pregnant?	○N	○Y	Date of last menstrual period _____		

Please explain all YES answers below or on continuation sheet:

CARDIAC SCREENING

As an adult, have you had or experienced?

Abnormal ECG	○N	○Y	Hypertension	○N	○Y	recent reading_____
Sedentary Life Style	○N	○Y	Diabetes	○N	○Y	HgA_{1C} _____
Family History of Heart Attack before age 45	○N	○Y	High Cholesterol	○N	○Y	recent reading_____
			Tobacco Use	○N	○Y	packs / day_____
Heart Attack	○N	○Y	Prolonged Chest Pain	○N	○Y	
Shortness of Breath	○N	○Y	Fainting spells / Syncope	○N	○Y	

Please explain all YES answers below or on continuation sheet:

Name: _____

IMMUNIZATION SCREENING

Please list the date(s) you obtained immunizations / prophylaxis against the following diseases:

PPD (TB test) - must be within last 12 months: Date_____ Result_____

	Date	Type	Date unknown	None
Tetanus[1]	_____	_____	☐	☐
Hepatitis A Series: Dose 1	_____	_____	☐	☐
Dose 2	_____	_____	☐	
Hepatitis B Series: Dose 1	_____	_____	☐	☐
Dose 2	_____	_____	☐	
Dose 3	_____	_____	☐	
Cholera	_____	_____	☐	☐
Diphtheria [1]	_____	_____	☐	☐
Influenza (most recent)	_____	_____	☐	☐
Immunoglobulin (IG)	_____	_____	☐	☐
Malaria	_____	_____	☐	
Measles, Mumps, Rubella (MMR)	_____	_____	☐	☐
Polio	_____	_____	☐	☐
Typhoid Fever	_____	_____	☐	☐
Yellow Fever	_____	_____	☐	☐

Other: Please provide complete information on Continuation Sheet

[1] May be given as part of TD vaccination

Are you aware of any other medical condition(s) that may affect your suitability for sea duty?

○No ○Yes

If yes, please explain on the continuation page

If you have any questions, please contact the appropriate Health Services Office:

Marine Operations Atlantic (757) 441-6320 Marine Operations Pacific (206) 553-8704

Continuation page attached? ○No ○Yes

The information provided is complete to the best of my knowledge.

_____

Signature_____ Date _____

Forward to the following ships: 1. _____ 2. _____ 3._____

MEDICALLY CLEARED FOR SEA DUTY BY HISTORY ○Y ○N ○NEED MORE INFO

_____ _____

MOA / MOP Regional Director of Health Services Date (mm / dd / yy)

NOAA Health Services Questionnaire Continuation Page

Name: _____